1.0 Description of Service

The covered services are assessments and treatments performed by qualified Independent Practitioner (IP) service providers from the following disciplines:

1.1 Audiology Services

Assessment

Service may include testing and/or clinical observation, as appropriate for chronological or developmental age, for one or more of the following areas, and shall yield a written evaluation report.

- auditory sensitivity (including pure tone air and bone conduction, speech detection, and speech reception thresholds)
- auditory discrimination in quiet and noise
- impedance audiometry (tympanometry and acoustic reflex testing)
- hearing aid evaluation (amplification selection and verification)
- central auditory function
- evoked otoacoustic emissions
- brainstem auditory evoked response (a.k.a., ABR)

Treatment

Service may include one or more of the following, as appropriate:

- auditory training
- speech reading
- augmentative and alternative communication training (including sign language and cued speech training)

1.2 Speech/Language (ST) Services

Assessment

Service must include testing and/or clinical observation, as appropriate for chronological or developmental age, for **all** the following areas, and shall yield a written evaluation report.

- expressive language
- receptive language
- auditory processing, discrimination, and memory
- augmentative and alternative communication
- vocal quality
- resonance patterns
- articulation/phonological development
- pragmatic language
- rhythm/fluency
- oral mechanism/swallowing
- hearing status based on pass/fail criteria

Note: Any of the above named areas of functioning may also be addressed as a specialized assessment, following performance of the overall evaluation of the child's speech/language skills.

Treatment
Service may include one or more of the following, as appropriate:

- articulation/phonological training
- language therapy
- augmentative and alternative communication training
- auditory processing/discrimination training
- fluency training
- voice therapy
- oral motor training; swallowing therapy
- speech reading

1.3 Occupational Therapy (OT) Services

Assessment
Service may include testing and/or clinical observation, as appropriate for chronological or developmental age, for one or more of the following areas, and shall yield a written evaluation report.

- activities of daily living assessment
- sensorimotor assessment
- neuromuscular assessment
- fine motor assessment
- feeding/oral motor assessment
- visual perceptual assessment
- perceptual motor development assessment
- musculo-skeletal assessment
- gross motor assessment
- functional mobility assessment
- pre-vocational assessment

Treatment
Service may include one or more of the following, as appropriate:

- activities of daily living training
- neuromuscular development
- muscle strengthening, endurance training
- feeding/oral motor training
- adaptive equipment application
- visual perceptual training
- facilitation of gross motor skills

- facilitation of fine motor skills
- fabrication and application of splinting and orthotic devices
- manual therapy techniques
- sensorimotor training
- pre-vocational training
- functional mobility training
- perceptual motor training

1.4 Physical Therapy (PT) Services

Assessment

Service may include testing and/or clinical observation, as appropriate for chronological or developmental age, for one or more of the following areas, and shall yield a written evaluation report.

- neuromotor assessment
- range of motion, joint integrity, functional mobility, and flexibility assessment
- gait, balance, and coordination assessment
- posture and body mechanics assessment
- soft tissue assessment
- pain assessment
- cranial nerve assessment
- clinical electromyographic assessment
- nerve conduction, latency and velocity assessment
- manual muscle test
- reflex integrity
- activities of daily living assessment
- cardiac assessment
- pulmonary assessment
- sensory motor assessment
- feeding/oral motor assessment

Treatment

Service may include one or more of the following, as appropriate:

- manual therapy techniques
- fabrication and application of orthotic device
- therapeutic exercise
- functional training
- facilitation of motor milestones
- sensory motor training
- cardiac training
- pulmonary enhancement

- adaptive equipment application
- feeding/oral motor training
- activities of daily living training
- gait training
- posture and body mechanics training
- muscle strengthening
- gross motor development
- modalities
- therapeutic procedures
- hydrotherapy
- manual manipulation
- wheelchair management

1.5 Respiratory Therapy (RT) Services

Assessment

Service may include testing and/or clinical observation, as appropriate for evaluation of pulmonary status, for one or more of the following areas; and shall yield a written evaluation report.

- collection of specimen for arterial blood gas analysis (ABGs)
- pulmonary function studies
- breath sounds
- acute and chronic lung disease patients
- ventilator dependent patients

Treatment

Service may include one or more of the following, as appropriate:

- bronchodilator and aerosol therapy
- oxygen therapy
- sterile and non-sterile suctioning techniques
- tracheostomy care
- chest vibrations, postural drainage, and breathing techniques
- ventilator care
- monitoring of respiratory status (ABGs, pulse oximetry, pulmonary function studies, sputum cultures, apnea-bradycardiac monitors, etc.)

2.0 Eligible Recipients

2.1 General Provisions

Medicaid-eligible individuals with a need for specialized therapy services confirmed by a licensed physician, physician assistant or nurse practitioner are eligible to receive specialized therapies.

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

Note: There is a required referral process for a recipient who is enrolled through the Carolina ACCESS (CA) program.

Note: The IP program **cannot** be billed for Medicaid recipients who are enrolled through an HMO. These services are always classified as being "in-plan."

2.2 Limitations

Recipients must be under the age of 21 years and must be Medicaid-eligible when the services are provided.

2.3 Special Provisions

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that provides recipients under the age of 21 with medically necessary health care to correct or ameliorate a defect, physical or mental illness or a condition identified through a screening examination. While there is no requirement that the service, product or procedure be included in the State Medicaid Plan, it must be listed in the federal law at 42 U.S.C. § 1396d(a). Service limitations on scope, amount or frequency described in this coverage policy do not apply if the product, service or procedure is medically necessary.

The Division of Medical Assistance's policy instructions pertaining to EPSDT are available online at http://www.dhhs.state.nc.us/dma/prov.htm.

3.0 When the Service is Covered

All services must be medically necessary.

3.1 Physical Therapy

Medicaid accepts the medical necessity criteria for beginning, continuing, and terminating treatment as published by the American Physical Therapy Association in their most recent edition of *Physical Therapy: Guide to Physical Therapist Practice, Part Two: Preferred Practice Patterns.*

Exception: A specific "treatable" functional impairment that impedes ability to participate in productive activities needs to be identified as the basis for beginning treatment rather than a specific "reversible" functional impairment that impedes ability to participate in productive activities.

3.2 Occupational Therapy

Medicaid accepts the medical necessity criteria for beginning, continuing, and terminating treatment as published by the American Occupational Therapy Association in their most recent edition of *Occupational Therapy Practice Guidelines Series*.

Exception: A specific "treatable" functional impairment that impedes ability to participate in productive activities needs to be identified as the basis for beginning treatment rather than a specific "reversible" functional impairment that impedes ability to participate in productive activities.

3.3 Speech/Language-Audiology Therapy

Medicaid accepts the medical necessity criteria for Speech/Language-Audiology therapy treatment as follows:

- *Basic Elements of Coverage of Speech-Language Pathology and Dysphagia Services* (http://cms.hhs.gov/manuals/pub13/pub_13.asp)- Section 3101.10A) **and**
- *Special Instructions for Medical Review of Dysphagia Claims* (http://cms.hhs.gov/manuals/108_pim/pim83c06s07.asp#Sect10) **and**
- The following criteria for *Birth to 21 Years*.

Language Impairment Classifications ***Infant/Toddler – Birth to 3 Years***	
Mild	• Standard scores 1 to 1.5 standard deviations below the mean, **or** • Scores in the 7th –15th percentile, **or** • A language quotient or standard score of 78 – 85, **or** • A 20% - 24% delay on instruments that determine scores in months, **or** • Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.
Moderate	• Standard scores 1.5 to 2 standard deviations below the mean, **or** • Scores in the 2nd – 6th percentile, **or** • A language quotient or standard score of 70 – 77, **or** • A 25% - 29% delay on instruments which determine scores in months, **or** • Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.
Severe	• Standard scores more than 2 standard deviations below the mean, **or** • Scores below the 2nd percentile, **or** • A language quotient or standard score of 69 or lower, **or** • A 30% or more delay on instruments that determine scores in months, **or** • Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.

Preschool – Age 3 Years to Kindergarten-Eligible Language Impairment Classifications	
Mild	• Standard scores 1 to 1.5 standard deviations below the mean, **or** • Scores in the 7^{th} – 15^{th} percentile, **or** • A language quotient or standard score of 78 – 85, **or** • If standard scores are not obtainable or are deemed unreliable, information gathered from checklists, observations, etc. that demonstrates a 6 to 12 month delay, **or** • Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.
Moderate	• Standard scores 1.5 to 2 standard deviations below the mean, **or** • Scores in the 2^{nd} – 6^{th} percentile, **or** • A language quotient or standard score of 70 – 77, **or** • If standard scores are not obtainable or are deemed unreliable, information gathered from checklists, observations, etc. that demonstrates a 13 to 18 month delay, **or** • Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.
Severe	• Standard scores more than 2 standard deviations below the mean, **or** • Scores below the 2^{nd} percentile, **or** • A language quotient or standard score of 69 or lower, **or** • If standard scores are not obtainable or are deemed unreliable, information gathered from checklists, observations, etc. that demonstrates a 19 month or more delay, **or** • Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.

Language Impairment Classifications School Age – Kindergarten-Eligible to Age 21	
Mild	• Standard scores 1 to 1.5 standard deviations below the mean, **or** • Scores in the 7^{th} – 15^{th} percentile, **or** • A language quotient or standard score of 78 –85, **or** • If standard scores are not obtainable or are deemed unreliable, information gathered from checklists, observations, etc. that demonstrate a 1 year to 1 year, 6 month delay, **or** • Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics, or pragmatics.
Moderate	• Standard scores 1.5 to 2 standard deviations below the mean, **or** • Scores in the 2^{nd} – 6^{th} percentile, **or** • A language quotient or standard score of 70 – 77, **or** • If standard scores are not obtainable or are deemed unreliable, information gathered from checklists, observations, etc. that demonstrates a 1 year, 7 month to 2 year delay, **or** • Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.
Severe	• Standard scores more than 2 standard deviations below the mean, **or** • Scores below the 2^{nd} percentile, **or** • A language quotient or standard score of 69 or lower, **or** • If standard scores are not obtainable or are deemed unreliable, information gathered from checklists, observations, etc. that demonstrates a 2 year or more delay, **or** • Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.

Articulation/Phonology Impairment Classifications All Ages	
Mild	• Standard scores 1 to1.5 standard deviations below the mean, **or** • Scores in the 7^{th} – 15^{th} percentile, **or** • One phonological process that is not developmentally appropriate, with a 20% occurrence, **or** • Additional documentation of examples indicating a delay, such as percent consonant correct measures, measures of intelligibility, tests of stimulability, etc. Child is expected to have few articulation errors, generally characterized by typical substitutions, omissions, and/or distortions. Intelligibility not greatly affected but errors are noticeable.
Moderate	• Standard scores 1.5 to 2 standard deviations below the mean, **or** • Scores in the 2^{nd} – 6^{th} percentile, **or** • Two or more phonological processes that are not developmentally appropriate, with a 20% occurrence, **or** • At least one phonological process that is not developmentally appropriate, with a 21% - 40% occurrence, **or** • Additional documentation of examples indicating a delay, such as percent consonant correct measures, measures of intelligibility, tests of stimulability, etc. Child typically has 3 - 5 sounds in error, which are one year below expected development. Error patterns may be atypical. Intelligibility is affected and conversational speech is occasionally unintelligible.
Severe	• Standard scores more than 2 standard deviations below the mean, **or** • Scores below the 2^{nd} percentile, **or** • Three or more phonological processes that are not developmentally appropriate, with a 20% occurrence, **or** • At least one phonological process that is not developmentally appropriate, with more than 40% occurrence, **or** • Additional documentation of examples indicating a delay, such as percent consonant correct measures, measures of intelligibility, tests of stimulability, etc. Child typically has more than five sounds in error with a combination of error types. Inconsistent errors and lack of stimulability is evident. Conversational speech is generally unintelligible.

Articulation Treatment Goals Based on Age of Acquisition	
Age of Acquisition	**Treatment Goal(s)**
Before Age 2	Vowel sounds
After Age 2, 0 months	/m/, /n/, /h/, /w/, /p/, /b/
After Age 3, 0 months	/f/, /k/, /g/, /t/, /d/
After Age 4, 0 months	/n/, /j/
After Age 5, 0 months	voiced th, sh, ch, /l/, /v/, j
After Age 6, 0 months	/s/, /r/, /z/, /s/ blends, /r/ blends, vowelized /r/, voiceless th, /l/ blends
In using these guidelines for determining eligibility, total number of errors and intelligibility should be considered. A 90% criterion is roughly in accord with accepted educational and psychometric practice that considers only the lowest 5% - 10% of performances on a standardized instrument to be outside the normal range.	

Phonology Treatment Goals Based on Age of Acquisition of Adult Phonological Rules	
Age of Acquisition	**Treatment Goal(s)**
After age 2 years, 0 months	Syllable reduplication
After age 2 years, 6 months	Backing, deletion of initial consonants, metathesis, labialization, assimilation
After age 3 years, 0 months	Final consonant devoicing, fronting of palatals and velars, final consonant deletion, weak syllable deletion /syllable reduction, stridency deletion/ stopping, prevocalic voicing, epenthesis
When children develop idiosyncratic patterns, which exist after age 3 years, 0 months to 3 years, 5 months, they likely reflect a phonological disorder and should be addressed in therapy. Minor processes, or secondary patterns such as glottal replacement, apicalization and palatalization typically occur in conjunction with other major processes. These minor processes frequently correct on their own as those major processes are being targeted.	
After age 4 years, 0 months	Deaffrication, vowelization/vocalization, cluster reduction, gliding

Eligibility Guidelines for Stuttering	
Borderline/Mild	3 – 10 sw/m or 3% - 10% stuttered words of words spoken, provided that prolongations are less than 2 seconds and no struggle behaviors and that the number of prolongations does not exceed total whole-word and part-word repetitions.
Moderate	More than 10 sw/m or 10% stuttered words of words spoken, duration of dysfluencies up to 2 seconds; secondary characteristics may be present.
Severe	More than 10 sw/m or 10% stuttered words of words spoken, duration of dysfluencies lasting 3 or more seconds, secondary characteristics are conspicuous.
Note: When the percentage of stuttered words fall in a lower severity rating and duration and/or presence of physical characteristics falls in a higher severity rating, the service delivery may be raised to the higher level.	

Differential Diagnosis for Stuttering

Characteristics of normally dysfluent children:

- Nine dysfluencies or less per every 100 words spoken.
- Majority types of dysfluencies include: whole-word, phrase repetitions, interjections, and revisions.
- No more than two unit repetitions per part-word repetition (e.g., b-b-ball, but not b-b-b ball.).
- Schwa is not perceived (e.g., bee-bee-beet. is common, but not buh-buh-buh-beet).
- Little if any difficulty in starting and sustaining voicing; voicing or airflow between units is generally continuous; dysfluencies are brief and effortless.

Differential Diagnosis for Stuttering, continued

The following information may be helpful in monitoring children for fluency disorders. This information indicates dysfluencies that are considered typical in children, crossover behaviors that may be early indicators of true stuttering and what characteristics are typical of true stutterers.

More Usual (Typical Dysfluencies)

- Silent pauses; interjections of sounds, syllables or words; revisions of phrases or sentences; monosyllabic word repetitions or syllable repetitions with relatively even rhythm and stress; three or less repetitions per instance; phrase repetitions.

Crossover Behaviors

- Monosyllabic word repetitions or syllable repetitions with relatively even stress and rhythm but four or more repetitions per instance, monosyllabic word repetitions or syllable repetitions with relatively uneven rhythm and stress with two or more repetitions per instance.

More Unusual (Atypical Dysfluencies)

- Syllable repetitions ending in prolongations; sound, syllable or word prolongations; or prolongations ending in fixed postures of speech mechanism, increased tension noted in the act.

- **Augmentative and Alternative Communication** (AAC) standards for treatment from ASHA *Augmentative Communication Strategies*, volume II, 1988:

Note:

1. These criteria define parameters for involvement and services of the therapist for evaluation and treatment, not purchases of the devices or equipment.
2. These criteria are not intended to override or replace existing limits on coverage for services, either as dollar amounts or as acceptable billing codes.

"The primary purpose of an augmentative communication program is to enhance the quality of life for persons with severe speech and language impairments in accordance with each persons preferences, abilities, and life style. Augmentative communication programs perform the continuing, vital, and unique task of helping these individuals develop communication skills they will need throughout the course of their lives. The programs also encourage the development of each individual's initiative, independence, and sense of personal responsibility and self-worth."

AAC treatment programs are developed in accordance with Preferred Practices approved by ASHA.
These services include:

- Counseling
- Product Dispensing
- Product Repair/Modification
- AAC System and/or Device Treatment/Orientation
- Prosthetic/Adaptive Device Treatment/Orientation
- Speech/Language Instruction

AAC treatment codes are used for the following:

- Therapeutic intervention for device programming and development
- Intervention with family members/caregivers/support workers, and individual for functional use of the device
- Therapeutic intervention with the individual in discourse with communication partner using his/her device

The above areas of treatment need to be performed by a licensed Speech-Language Pathologist with education and experience in augmentative communication to provide therapeutic intervention to help individuals communicate effectively using their device in all areas pertinent to the individual. Treatment will be authorized when the results of an authorized AAC assessment recommend either a low-tech or a high-tech system.

Any time the individual's communication needs change for medical reasons, additional treatment sessions should be requested. In addition, if an individual's device no longer meets his/her communication needs, additional treatment sessions should be requested.

Possible reasons to request authorization for additional treatment include:

- Update of device
- Replacement of current device
- Significant revisions to the device and/or vocabulary
- Medical changes

3.3.1 Audiology Therapy (aural rehabilitation) Practice Guidelines

The basis for audiology referral is the presence of any degree or type of hearing loss on the basis of the results of an audiologic (aural) rehabilitation assessment or presence of impaired or compromised auditory processing abilities on the basis of the results of a central auditory test battery.

Examples of deficits for initiating therapy may include, **but are not limited to**, the following:

- Hearing loss (any type) >25 dBHL at 2 or more frequencies in either ear
- Standard Score more than 1 SD (standard deviation) below normal for chronological age on standardized tests of language, audition, speech, or auditory processing
- Impaired or compromised auditory processing abilities as documented on the basis of the results of a central auditory test battery
- Less than 1-year gain in skills (auditory, language, speech, processing) during a 12-month period of time

Underlying Referral Premise
Aural rehabilitation will:

1. facilitate receptive and expressive communication of individuals with hearing loss, and/or,
2. achieve improved, augmented or compensated communication processes, and/or,
3. improve auditory processing, listening, spoken language processing, overall communication process, and/or,
4. benefit learning and daily activities.

Evaluation – Audiologic (Aural) Rehabilitation
Service delivery requires the following elements:

Note: Functioning of hearing aids, assistive listening systems/devices, and sensory aids must be checked prior to the assessment.

Through interview, observation, and clinical testing, evaluate (in both clinical and natural environments):

- Client history
- Reception, comprehension, and production of language in oral, signed or written modalities
- Speech and voice production
- Perception of speech and non-speech stimuli in multiple modalities
- Listening skills
- Speechreading
- Communication strategies

Include the ICD-9-CM diagnosis code. Determine specific functional limitation(s) (must be measurable) for client.

Evaluation – Central Auditory Processing Disorders (CAPD)

Note: CAPD assessment is to be interdisciplinary (involving audiologist, speech/language pathologist, and neuropsychologist) and is to include tests to evaluate the overall communication behavior, including spoken language processing and production, and educational achievement of individuals.

Through interview, observation, and clinical testing, evaluate:

- Communication, medical, educational history.
- Central auditory behavioral tests. Types of central auditory behavioral tests include:
  - Tests of temporal processes
  - Tests of dichotic listening
  - Low redundancy monaural speech tests
  - Tests of binaural interaction
- Central auditory electrophysiologic tests include:
  - Auditory brainstem response (ABR)
  - Middle latency evoked response (MLR)
  - N1 and P2 (late potentials) responses and P300
  - Mismatched negativity (MMN)
  - Middle ear reflex
  - Crossed suppression of otoacoustic emissions

Interpretations are derived from multiple tests based on age-appropriate norms. Evaluation may involve a series of tests given over a period of time at one or more clinic appointments. Procedures in a CAPD battery should be viewed as separate entities for purposes of service provision and reimbursement

Include the ICD-9-CM diagnosis code. Determine specific functional limitation(s) (must be measurable) for client.

Examples of Functional Deficits
Examples of functional deficits may include, **but are not limited to**, the following:

- Inability to hear normal conversational speech
- Inability to hear conversation via the telephone
- Inability to identify, by hearing, environmental sounds necessary for safety (i.e., siren, car horn, doorbell, baby crying, etc.)
- Inability to understand conversational speech (in person or via telephone)
- Inability to hear and/or understand teacher in classroom setting
- Inability to hear and/or understand classmates during class discussion
- Inability to hear/understand co-workers/supervisors during meetings at work
- Inability to read on grade level (as result of auditory processing difficulty)
- Inability to localize sound

Treatment Planning
The treatment plan is developed in conjunction with client/caregiver and medical provider and considers performance in both clinical and natural environments. Treatment should be culturally appropriate. Short- and long-term functional communication goals and specific objectives are determined from assessment. The amount of time, place(s), and professional or lay person(s) involved must be designated. Generalization of skills and strategies is enhanced by extending practice to the natural environment through collaboration among key professionals. Goals and objectives are reviewed periodically to determine appropriateness and relevance.

- Short-term Goals: Improve the overall communication process as defined in functional limitations.
- Long-term Goals: Decrease or eliminate functional deficit.

Note: Rate of improvement varies by client, depending on the severity level, compliance with therapy, and the context in which the client lives and performs activities of daily living.

Discharge/Follow-up
Discharge
The therapy will be discontinued when one of the following criteria is met:

- Client has achieved functional goals and outcomes.
- Client's performance is WNL for chronological age on standardized measures of language, speech, audition, and/or auditory processing (as applicable to the client).
- Client/parent are non-compliant with treatment plan.

At discharge, audiologist will identify indicators for potential follow-up care.

Follow-Up
Readmittance to audiologic (aural) rehabilitation may result from changes in functional status, living situation, school or child care, caregiver, or personal interests.

3.4 Respiratory Therapy

Medicaid accepts the following medical necessity criteria for respiratory therapy treatment provided through the IP Program to Medicaid recipients ages birth to 21 years.

Asthma Guidelines	
Level I – Assessment Stage 1 (Mild Intermittent)	• Symptoms ≤ 2 times a week • Nighttime symptoms ≤ 2 times a month • Exacerbations brief (few hours to a few days); intensity may vary • PEF ≥ 80% predicted, PEF variability < 20%
Level II – Assessment and Treatment Stage 2 (Mild Persistent)	• Symptoms > 2 times a week but < 1 time a day • Nighttime symptoms > 2 times a month • Exacerbations may affect activity • PEF ≥ 80% predicted, PEF variability 20% to 30%
Level III – Assessment and Treatment Stage 3 (Moderate Persistent)	• Daily symptoms • Nighttime symptoms > 2 times a month • Daily use of inhaled short-acting $beta_2$-agonist • Exacerbations affect activity • Exacerbations ≥ 2 times a week; may last days • PEF < 80% predicted, PEF variability > 30%
Level IV – Assessment and Treatment Stage 4 (Severe Persistent)	• Continual symptoms • Frequent nighttime symptoms • Limited physical activity • Frequent exacerbations • PEF < 60% predicted: PEF variability > 30%

Service delivery requires the following elements:

Evaluation
Evaluate the following through interview, observation, and clinical testing: • Client's history of episodic symptoms • Physical assessment (HR, RR, BBS) • Oximetry • PEF measurement • Medication/treatment compliance • Inhaler technique • Lifestyle (e.g., days missed from school or day care and limitations to normal activities • Client-provider communication and client satisfaction Evaluation outcomes should include: • ICD-9-CM code • Specific functional limitation(s), which must be measurable and quantified Examples include but are not limited to: • Respiratory symptoms $\geq$ 2 times a week • Reduction in usual activities $\geq$ 2 times in 1 month due to respiratory symptoms • Respiratory symptoms disturbing sleep $\geq$ 2 times in one month • More than 5 days missed from school in a six-month period related to respiratory symptoms • More than one hospital or ER admissions due to respiratory symptoms in a six-month period

Care Plan
Characteristics of the Care Plan include: • Development with the client/family and medical provider to determine severity level and pharmacological treatment • Short-term goals: e.g., improve respiratory status as defined in functional limitations • Long-term goals: e.g., decrease or eliminate functional deficit

Discharge/Follow-up
Discharge Therapy will be discontinued when one of the following criteria is met: ● Client has achieved functional goals and outcomes ● Client is able to follow prescribed therapy program independently or with assistance ● A physician orders discharge ● Client reaches age 21 ● Client/parent are non-compliant with treatment plan **Follow-up** At discharge, the respiratory therapist should identify indicators for potential follow-up care such as changes in functional status, living situation, school or childcare, or caregiver.

Chronic Respiratory Guidelines, excluding Asthma	
Level 1 – Assessment	● Occasional day and/or night symptoms ● Ability to clear secretions ● Ability to clear breath sounds ● Mildly limited physical activity or bedridden
Level II – Assessment and Treatment	● Daily and nightly symptoms ● Ability to clear secretions ● Ability to clear breath sounds ● Limited physical activity or bedridden
Level III – Assessment and Treatment	● Daily and nightly symptoms ● On-going use of inhaled short-acting beta$_2$-agonist ● Exacerbations affect activity ● Exacerbations $\geq$ 2 times a week; may last days
Level IV – Assessment and Treatment	● Continual symptoms ● Daily and nightly symptoms ● Limited physical activity/bedridden/house-confined ● Frequent exacerbations

Service delivery requires the following elements:

Evaluation
Evaluate the following through interview, observation, and clinical testing: • Client's history • Physical assessment (HR, RR, BBS) • Pulmonary assessment • Oximetry • PFT (if applicable) • ABG (if applicable) • Radiological findings Evaluation outcomes should include: • ICD-9-CM code • Specific functional limitation(s), which must be measurable and quantified Examples include but are not limited to: • Inability to remove secretions by means of spontaneous cough/ suctioning technique • PFTs below acceptable levels for 2 weeks • Inability to clean and maintain tracheostomy • Inability to maintain O_2 saturation at 94% or better • Unable to exert without shortness of breath • Unable to perform purse-lip and diaphragmatic breathing • Unable to wean from mechanical life support

Care Plan
Characteristics of the Care Plan include: • Development with the client/family and medical provider to determine treatment goals and outcomes • Short-term goals: e.g., improve respiratory status as defined in functional limitations • Long-term goals: e.g., decrease or eliminate functional deficit

Discharge/Follow-up
Discharge Therapy will be discontinued when one of the following criteria is met: • Client has achieved functional goals and outcomes • Client/family is able to follow prescribed therapy program independently or with assistance • A physician orders discharge • Client reaches age 21 • Client/family are non-compliant with treatment plan **Follow-up** At discharge, the respiratory therapist should identify indicators for potential follow-up care such as changes in functional status, living situation, school or childcare, or caregiver.

4.0 When the Service is Not Covered

OT, PT, ST, and RT are not covered when the following policy guidelines are not met.

Note: The IP program **cannot** be billed for Medicaid recipients who are enrolled through an HMO. These services are always classified as being "in-plan."

Note: There is a required referral process for a recipient who is enrolled through the CA program.

5.0 Requirements for and Limitations on Coverage

5.1 Patient's Location

A patient may receive IP therapy services in the office, home, school, through the Head Start program, and/or child care (i.e., regular and developmental day care) settings.

5.2 Treatment Services

The initial process for providing treatment, regardless of place of service, consists of the following steps and requirements:

1. All services must be provided according to a written plan.
2. The written plan for services must include defined goals for each therapeutic discipline.
3. Each plan must include a specific content, frequency and length of visits for each therapeutic discipline.
4. A verbal or a written order must be obtained for services***** prior to the start of the services. Backdating is not allowed.

*(*Services are all therapeutic PT/OT/ST/RT activities **beyond** the entry evaluations. This includes recommendations for specific programs, providers, methods, settings, frequency, and length of visits.)*

5. Service providers must review and renew or revise plans and goals no less often than every six months, to include obtaining another dated physician signature for the renewed or revised orders. There will be no payment for services rendered more than 6 months **after** the most recent physician order signature date **and before** the following renewal/revision signature date. The signature date must be the date the physician signs the order. Backdating is not allowed.
6. Up to six unmanaged visits per discipline, per provider type are allowed without prior approval. Evaluations, re-evaluations, and/or multidisciplinary evaluations are **not** counted in the six unmanaged visits. If six therapy visits occur before six months from a physician's order for any specific discipline, and if services need to be continued for additional visits, The Carolinas Center for Medical Excellence (CCME) may approve continued services without an additional physician order under the following conditions:******
    a. The continued services must have a written plan with defined goals for each therapeutic discipline.
    b. The written plan must include a specific content, duration, frequency and length of visits for each therapeutic discipline (e.g., PT services to include [list treatment modalities] for six weeks at three visits per week for 30 minutes each visit).
    c. The request for continuation of services must be accompanied by the documentation of the plan, goals and outcomes for the previous service interval.
    d. There will be no payment for services rendered in excess of six visits and before the date of the approval for continuation of services.
7. If a patient between birth and five years of age has had a Developmental Evaluation Center (DEC) or DEC-approved evaluation and has an Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP), that will change the time for required CCME approval for continued services from 6 visits to 6 months after the initial physician's order. The initial claim and the request for continued services must both include the date of the Physician's order in box 15 on the CMS-1500 (HCFA-1500). If the date is not included, the claim is subject to the same six visit approval requirement as all other claims.
8. Faxed orders and faxed signatures are permissible and serve the same purposes for documentation as an original signature on an original form or orders sheet.

****Note:** The screening thresholds (6 visits) being applied initially are designed to meet the prior approval requirements of the N.C. General Assembly while Medicaid collects data on which future, more clinically relevant and discipline-specific criteria will be based. The intention is to allow each discipline to assist in defining policy guidelines consistent with recommendations from the authoritative bodies for each discipline (national standards, best practice guidelines).

5.3 Prior Approval

After six unmanaged visits, prior approval is required for continued treatment. **Prior approval is for medical approval only and does not guarantee payment or ensure recipient eligibility on the date of service.** The prior approval process does not start until all six visits have been used. However, the prior approval request should be made at approximately the 2nd or 3rd visit to allow sufficient time for processing.

A prior approval request form signed by the provider must be faxed to CCME for treatment to be continued. If appropriate, CCME will authorize services for a specific number of units through a specific length of time. Units should be requested based on the CPT code billed. If the CPT code is billed by event, then one unit should be requested. If the CPT code is billed in 15-minute increments with 15 minutes equaling one unit, then the number of units to be provided should be requested. Once these limits have been reached, prior approval must again be requested for continued treatment.

Medicaid's initial authorization for duration of treatment cannot exceed the lowest of the following ranges with a cap of 52 visits during a 6-month time period:

Physical and Occupational Therapy:

a. the maximum of the usual range of visits for a condition as published in the most recent edition of *Physical Therapy: Guide to Physical Therapist Practice, Part Two: Preferred Practice Patterns* or *Occupational Therapy Practice Guidelines Series*, **or**
b. the number of visits requested by the therapist, not to exceed a time limit of 6 months

Speech/Language-Audiology Therapy:

a. for a recipient with:
   - Mild Impairment range of visits: 6 – 26
   - Moderate Impairment range of visits: Up to 46
   - Severe Impairment range of visits: Up to 52,

   or
b. the number of visits requested by the therapist, not to exceed a time limit of 6 months
c. Audiology: 30 to 60 minute sessions, 1 to 3 times a week, in increments of 6 months (up to 52 visits). Length of visit and duration are determined by the client's level of severity and rate of change.

Respiratory Therapy:
Functional performance measures and potential for change determine whether the intervention is needed and the frequency with which it will be provided. Length of visit and duration are determined by the client's level of severity and rate of change.

Asthma Guidelines:
Level I – Stage 1 (Mild Intermittent)
Average Time: 30 – 60 minutes face-to-face with client
Maximum Units: 0

Level II – Stage 2 (Mild Persistent)
Average Time: 30 – 60 minutes face-to-face with client
Average Days: 2 days per week
Average Procedures: 3 procedures
Maximum Units: 156

Level III – Stage 3 (Moderate Persistent)
Average Time: 30 – 60 minutes face-to-face with client
Average Days: 3 days per week
Average Procedures: 3 procedures
Maximum Units: 234

Level IV – Stage 4
Average Time: 30 – 90 minutes face-to-face with client
Average Days: 3 days per week
Average Procedures: 3 procedures
Maximum Units: 234

Chronic Respiratory Guidelines:
Level I
Average Time: 60 minutes face-to-face with client
Maximum Units: 0

Level II
Average Time: 60 minutes face-to-face with client
Average Days: 2 days per week
Average Procedures: 3 procedures
Maximum Units: 156

Level III
Average Time: 60 minutes face-to-face with client
Average Days: 3 days per week
Average Procedures: 4 procedures
Maximum Units: 312

Level IV
Average Time: 60 – 90 minutes face-to-face with client
Average Days: 5 days per week
Average Procedures: 6 procedures
Maximum Units: 780

No more than 52 visits in a 6-month period will be allowed without reauthorization.

Prior approval authorizations do not transfer if the recipient changes IP providers.

Note: If a recipient has had a DEC evaluation, prior approval is not required for the first six months. Refer to **item #7, Section 5.2, Treatment Services**, for information on DEC evaluations.

Note: HMO and Medicare recipients are exempt from the prior approval process.

5.4 Amount of Service

The amount of service is determined by the prior approval process.

5.5 Other Limitations

Assessment Services

A maximum of two hours of assessment services, for each type of service, is billable for each assessment. Each written evaluation report should contain a final summary listing the diagnosis/statement of the problem including the primary medical diagnosis, if known, and a secondary treatment-related diagnosis, as well as the recommendations for treatment. The diagnosis should include a statement concerning the degree of severity of each condition exhibited by the patient. The summary should also indicate whether the child has received any known assessments within the past six months for the type of service being billed.

For occupational therapy (OT), physical therapy (PT), and respiratory therapy (RT), assessment must occur within **12 months** of the requested beginning date of treatment. When continued treatment is requested, an annual reassessment summary of the child's status and performance must be submitted.

For audiology services (AUD) and speech/language services (ST), a written report of an assessment must occur within **6 months** of the requested beginning date of treatment. When continued treatment is requested, an annual reassessment report must be submitted.

Assessment services **do not include** interpretive conferences, educational placement or care planning meetings, or mass or individual screenings aimed at selecting children who may have special needs. Time spent for preparation, report writing, processing of claims, documentation regarding billing or service provision, and/or travel is not billable to the Medicaid program or to any other payment source since it is a part of the assessment process that was considered in the determination of the rate per unit of service.

Treatment Services

All treatment services shall be provided on an individualized basis with the exception of speech/language services, which include group speech therapy with a maximum total number (i.e., both non-eligible and Medicaid-eligible recipients) of four children per group.

Treatment services **do not include** consultation activities, specific objectives involving English as a second language or a treatment plan primarily dealing with maintenance/monitoring activities. Time spent for preparation, processing of claims, documentation regarding billing or service provision, and/or travel is not billable to the Medicaid program or to any other payment source since it is a part of the treatment process which was considered in the determination of the rate per unit of service.

6.0 Providers Eligible to Bill for the Service

6.1 Audiology

Eligible providers must have:

1. a valid license issued by the Board of Examiners for Speech and Language Pathologists and Audiologists,
2. a master's degree in Audiology, and
3. an ASHA Certificate of Clinical Competence (i.e., CCC) in Audiology, or there must be documentation that the service provider **has completed**:
    a. the requirements and work experience necessary for the Audiology CCC, or
    b. the academic master's degree program and is acquiring the supervised work experience necessary to qualify for the Audiology CCC.

6.2 Speech/Language

Eligible providers must have:

1. a valid license issued by the Board of Examiners for Speech and Language Pathologists and Audiologists,
2. a master's degree in Speech/Language Pathology, and
3. an ASHA Certificate of Clinical Competence (i.e., CCC) in Speech/Language Pathology, or there must be documentation that the service provider **has completed**:
    a. the requirements and work experience necessary for the Speech/Language Pathology CCC, or
    b. the academic master's degree program and is acquiring the supervised work experience necessary to qualify for the Speech/Language Pathology CCC.
4. Treatment services may be performed by a Speech/Language Pathology assistant who works under the supervision of an enrolled licensed practitioner.

6.3 Occupational Therapy

1. Assessment services must be provided by a licensed occupational therapist.
2. Treatment services must be provided by a licensed occupational therapist or a licensed occupational therapist assistant under the supervision of a licensed occupational therapist.
3. In addition to the above, assessment and treatment of children with special health care needs and/or developmental disabilities must be provided or supervised by a licensed occupational therapist with an annual 20 percent pediatric caseload.

6.4 Physical Therapy

1. Assessment services must be provided by a licensed physical therapist.
2. Treatment services must be provided by a licensed physical therapist or a licensed physical therapist assistant under the supervision of a licensed physical therapist.
3. In addition to the above, assessment and treatment of children with special health care needs and/or developmental disabilities must be provided or supervised by a licensed physical therapist with an annual 20 percent pediatric caseload

6.5 Respiratory Therapy

Assessment and treatment services must be provided by a respiratory therapist licensed under the provisions of the North Carolina Respiratory Care Practice Act.

7.0 Additional Requirements

7.1 Documenting Services

Each provider must maintain and allow DMA to access the following documentation for each individual:

- The patient name and Medicaid identification number.
- A copy of the treatment plan (IEP accepted for LEAs).
- A copy of the physician's order for treatment services.
- Description of services (intervention and outcome/client response) performed and dates of service.
- The duration of service (i.e., length of assessment and/or treatment session **in minutes**).
- The signature of the person providing each service. Treatment documentation must be signed by licensed therapist (e.g., PT co-signs for LPTA).
- A copy of each test performed or a summary listing all test results, and the written evaluation report.
- A copy of the completed prior approval form with the prior approval authorization number.

7.2 Requirements When the Type of Treatment Services are the Same as Those Provided by the Child's Public School or Early Intervention Program

If treatment services provided by the IP are the same type of health-related services the patient concurrently receives as part of the public school's special education program, a copy of the patient's current Individualized Education Plan (IEP) should also be obtained by the billing provider and maintained in the patient's file. Likewise, if the patient is concurrently receiving the same type of treatment service as part of an early intervention program (i.e., Head Start, early childhood intervention service or developmental day care program), a copy of the current IFSP should be obtained by the billing provider and maintained in the patient's file.

Furthermore, a copy of the patient's current IEP or IFSP should be obtained by the billing provider when the IP is providing services, under a contractual agreement, for the special education or early intervention program.

Note: The requirement to obtain a copy of the patient's IEP or IFSP does not apply to respiratory therapy services nor to other treatment services that do not extend beyond a maximum of four weeks of treatment.

8.0 Billing Guidelines

8.1 What May Be Billed

Assessment services are defined as the administration of an evaluation protocol, involving testing and/or clinical observation as appropriate for chronological or developmental age, which results in the generation of a written evaluation report. This protocol may include interviews with family, caregivers, other service providers, and/or teachers as a means to collect assessment data from inventories, surveys, and/or questionnaires.

Assessment services **do not include** interpretive conferences, educational placement or care planning meetings, or mass or individual screenings aimed at selecting children who may have special needs. Time spent for preparation, report writing, processing of claims, documentation regarding billing or service provision, and/or travel is not billable to the Medicaid program or to any other payment source since it is a part of the assessment process that was considered in the determination of the rate per unit of service.

Treatment services are defined as therapeutic procedures addressing the observed needs of the patient, which are performed and evaluated by the qualified service provider. As one component of the treatment plan, specific objectives involving face-to-face instruction to the family, caregivers, other service providers, and/or teachers **should be included** in order to facilitate carry-over of treatment objectives into the child's daily routine. All treatment services shall be provided on an individualized basis with the exception of speech/language services, which include group speech therapy with a maximum total number (i.e., both non-eligible and Medicaid-eligible recipients) of four children per group.

Treatment services **do not include** consultation activities, specific objectives involving English as a second language or a treatment plan primarily dealing with maintenance/monitoring activities. Time spent for preparation, processing of claims, documentation regarding billing or service provision, and/or travel is not billable to the Medicaid program or to any other payment source, since it is a part of the treatment process which was considered in the determination of the rate per unit of service.

8.2 Units of Service

The unit of service is determined by the CPT code used.

Audiology Assessment

Code	Unit of Service
92551	(1 unit = 1 event)
92552	(1 unit = 1 event)
92553	(1 unit = 1 event)
92555	(1 unit = 1 event)
92556	(1 unit = 1 event)
92557	(1 unit = 1 event)
92567	(1 unit = 1 event)
92568	(1 unit = 1 event)
92569	(1 unit = 1 event)
92571	(1 unit = 1 event)
92572	(1 unit = 1 event)
92576	(1 unit = 1 event)
92579	(1 unit = 1 event)
92582	(1 unit = 1 event)
92583	(1 unit = 1 event)
92585	(1 unit = 1 event)
92587	(1 unit = 1 event)
92588	(1 unit = 1 event)
92590	(1 unit = 1 event)
92591	(1 unit = 1 event)
92592	(1 unit = 1 event)
92593	(1 unit = 1 event)
92594	(1 unit = 1 event)
92595	(1 unit = 1 event)
92620	(1 unit = 60 min)
92621	(1 unit = each additional 15 min) must be billed with 92620
92626	(1 unit = 60 min)
92627	(1 unit = each additional 15 min) must be billed with 92626

Audiology Treatment

Code	Unit of Service
92507	(1 unit = 1 event)

Speech/Language Assessment

Code	Unit of Service
92506	(1 unit = 1 event)
92551	(1 unit = 1 event)
92607	(1 unit = 1 event)
92608	(1 unit = 1 event)
92610	(1 unit = 1 event)
92612	(1 unit = 1 event)
92626	(1 unit = 60 min)
92627	(1 unit = each additional 15 min) must be billed with 92626

Speech/Language Treatment

Code	Unit of Service
92507	(1 unit = 1 event)
92508	(1 unit = 1 event)
92526	(1 unit = 1 event)
92609	(1 unit = 1 event)
92630	(1 unit = 1 visit)
92633	(1 unit = 1 visit)

Occupational Therapy Assessment

Code	Unit of Service
92610	(1 unit = 1 event)
95831	(1 unit = 1 event)
95832	(1 unit = 1 event)
95833	(1 unit = 1 event)
95834	(1 unit = 1 event)
97003	(1 unit = 1 event)
97004	(1 unit = 1 event)
97750	(1 unit = 15 minutes)
97762	(1 unit = 15 minutes)

Occupational Therapy Treatment

Code	Unit of Service
29075	(1 unit = 1 event)
29085	(1 unit = 1 event)
29105	(1 unit = 1 event)
29125	(1 unit = 1 event)
29126	(1 unit = 1 event)
29130	(1 unit = 1 event)
29131	(1 unit = 1 event)
29240	(1 unit = 1 event)
29260	(1 unit = 1 event)
29280	(1 unit = 1 event)
29530	(1 unit = 1 event)
29540	(1 unit = 1 event)
92065	(1 unit = 1 event)
92526	(1 unit = 1 event)
97110	(1 unit = 15 minutes)
97112	(1 unit = 15 minutes)
97116	(1 unit = 15 minutes)
97140	(1 unit = 15 minutes)
97530	(1 unit = 15 minutes)
97533	(1 unit = 15 minutes)
97535	(1 unit = 15 minutes)
97542	(1 unit = 15 minutes)
97760	(1 unit = 15 minutes)
97761	(1 unit = 15 minutes)

Physical Therapy Assessment

Code	Unit of Service
92610	(1 unit = 1 event)
95831	(1 unit = 1 event)
95832	(1 unit = 1 event)
95833	(1 unit = 1 event)
95834	(1 unit = 1 event)
97001	(1 unit = 1 event)
97002	(1 unit = 1 event)
97750	(1 unit = 15 minutes)
97762	(1 unit = 15 minutes)

Physical Therapy Treatment

Code	Unit of Service
29075	(1 unit = 1 event)
29085	(1 unit = 1 event)
29105	(1 unit = 1 event)
29125	(1 unit = 1 event)
29126	(1 unit = 1 event)
29130	(1 unit = 1 event)
29131	(1 unit = 1 event)
29240	(1 unit = 1 event)
29260	(1 unit = 1 event)
29280	(1 unit = 1 event)
29405	(1 unit = 1 event)
29425	(1 unit = 1 event)
29505	(1 unit = 1 event)
29515	(1 unit = 1 event)
29530	(1 unit = 1 event)
29540	(1 unit = 1 event)
92526	(1 unit = 1 event)
97010	(1 unit = 1 event)
97012	(1 unit = 1 event)
97016	(1 unit = 1 event)
97018	(1 unit = 1 event)
97022	(1 unit = 1 event)
97024	(1 unit = 1 event)

Physical Therapy Treatment, continued

Code	Unit of Service
97026	(1 unit = 1 event)
97028	(1 unit = 1 event)
97032	(1 unit = 15 minutes)
97033	(1 unit = 15 minutes)
97034	(1 unit = 15 minutes)
97035	(1 unit = 15 minutes)
97036	(1 unit = 15 minutes)
97110	(1 unit = 15 minutes)
97112	(1 unit = 15 minutes)
97116	(1 unit = 15 minutes)
97124	(1 unit = 15 minutes)
97140	(1 unit = 15 minutes)
97530	(1 unit = 15 minutes)
97533	(1 unit = 15 minutes)
97535	(1 unit = 15 minutes)
97542	(1 unit = 15 minutes)
97602	(1 unit = 1 event)
97760	(1 unit = 15 minutes)
97761	(1 unit = 15 minutes)

Respiratory Therapy Assessment

Code	Unit of Service
94799	(1 unit = 1 event)

Respiratory Therapy Treatment

Code	Unit of Service
31502	(1 unit = 1 event)
31720	(1 unit = 1 event)
94010	(1 unit = 1 event)
94060	(1 unit = 1 event)
94150	(1 unit = 1 event)
94200	(1 unit = 1 event)
94240	(1 unit = 1 event)
94375	(1 unit = 1 event)
94657	(1 unit = 1 event)
94664	(1 unit = 1 event)
94667	(1 unit = 1 event)
94668	(1 unit = 1 event)
94760	(1 unit = 1 event)
99503	(1 unit = 1 event)

8.3 Payment Rate

Payment is calculated based on the lower of the billed usual and customary charges and Medicaid's maximum allowable rate.

8.4 Filing a Claim

Separate CMS-1500 claim forms must be filed for assessment and treatment services, and separate claim forms must be filed for each type of service provided**.** It should be noted that individual and group speech therapy, being the same type of service, can be listed on the same claim form.

Claims submitted for services provided to a child who has had a Developmental Evaluation Center (DEC) or DEC-approved evaluation and is therefore eligible for a six-month exemption from prior approval should follow the guidelines listed below.

Enter the date of the physician's order for services in block 15 on the CMS-1500 claim form (HCFA-1500). **Do not change the date once it is entered on the claim form.** If the date is not included on the claim, the service is subject to the same prior approval requirements as those for the six unmanaged visits.

Providers must include one of the discipline-specific ICD-9-CM diagnosis codes listed below as a secondary diagnosis on the claim.

V57.0 – Respiratory Therapy
V57.1 – Physical Therapy
V57.21 – Occupational Therapy
V57.3 – Speech Therapy

This does not change the requirement to bill the primary diagnosis that justifies the need for the specialized therapy. **Remember: The primary treatment ICD–9-CM diagnosis code must be entered first on the claim form. The discipline specific V code should follow the primary treatment code.**

Procedures should be billed using the most comprehensive CPT code to describe the service performed. The Correct Coding Initiative (CCI) was developed by the Centers for Medicare and Medicaid Services (CMS). It bundles the component procedures of the service into the comprehensive code. Only the comprehensive code is paid. If providers submit a claim using component codes in addition to comprehensive codes, the claim will deny. Providers receive an Explanation of Benefits (EOB) code indicating that the component code cannot be billed in addition to the comprehensive code. Additional information about CCI can be found online at http://www.hcfa.gov/medlearn/ncci.htm.

All claims should be sent electronically or mailed directly to EDS.

Note: Issuance of prior authorization does **not** preclude compliance with the Medicaid program's stipulation that all claims must be received by EDS within 365 days of the first date of service, in order to be accepted for processing and payment.

Refer to the ***Basic Medicaid Billing Guide*** for details regarding billing issues.

Refer to **Section 3.0, When the Service is Covered**, and **Section 5.2, Treatment Services**, for additional information.

9.0 Policy Implementation/Revision Information

Original Effective Date: October 1, 2002

Revision Information:

Date	Section Revised	Change
01/01/03	8.2, Units of Service	Conversion to CPT codes
02/26/03	5.2, Treatment Services, item #4 7.1, Documenting Services, 3rd bullet	Deleted text pertaining to verbal orders; effective with date of policy publication 10/01/02.
04/01/03	3.0, When the Service is Covered	Coverage criteria added for physical therapy, occupational therapy, and speech/language therapy.
04/01/03	5.2, Treatment Services, item #3 5.2, Treatment Services, item #4	The phrase "intensity of services" revised to "length of visits."

Revision Information, continued

Date	Section Revised	Change
04/01/03	5.3, Prior Approval	Prior approval criteria added for physical therapy, occupational therapy, and speech/language therapy.
04/01/03	8.2, Units of Service	End-dated codes replaced with CPT codes.
05/01/03	6.5, Respiratory Therapists	Updated licensure requirements for respiratory therapist; effective with date of policy publication 10/01/02.
06/01/03	5.2, Treatment Services, item #7	Text was revised to conform with billing guidelines; effective with date of publication 10/01/02.
06/01/03	8.4, Filing a Claim	Addition of V code diagnosis for treatment services and clarification of billing instructions.
07/01/03	3.4, Respiratory Therapy	Medical necessity criteria added for respiratory therapy.
07/01/03	5.3, Prior Approval Process	Respiratory therapy guidelines were added.
07/01/03	8.4, Filing a Claim	Diagnosis code V57.2 was corrected to V57.21, effective with date of change 06/01/03
10/01/03	3.3, Speech/Language-Audiology Therapy	This section was expanded to include Audiology Therapy; the title of the section was changed to Speech/Language-Audiology Therapy. Augmentative and Alternative Communication (AAC) standards for treatment were also added.
10/01/03	Section 3.3.1, Audiology Therapy (aural rehabilitation) Practice Guidelines	Section 3.3.1 was added to address audiology therapy practice guidelines.
10/01/03	Section 5.3.2, item c, Speech/Language-Audiology Therapy	Item c was added to address prior approval for audiology.
12/01/03	Section 5.0	The section was renamed from Policy Guidelines to Requirements for and Limitations on Coverage.

Revision Information, continued

Date	Section Revised	Change
1/1/05	Section 8.2, Physical Therapy Treatment	Code 97601 was end-dated
1/1/05	Section 8.2, Audiology Assessment	CPT code92589 was end-dated and replaced with 92620 and 92621
9/1/05	Section 2.0	A special provision related to EPSDT was added.
12/1/05	Section 2.3	The web address for DMA's EDPST policy instructions was added to this section.
1/1/06	Section 5.2 and 5.3	These sections were updated to reflect MRNC's name change to The Carolinas Center for Medical Excellence (CCME).
1/1/06	Section 8.2	CPT procedure code 95210 was end-dated and replaced with 92626, 92627, 92630 and 92633; 97504 was end-dated and replaced with 97760; 97520 was end-dated and replaced with 97761; 97703 was end-dated and replaced with 97762.
6/1/06	Section 8.2	CPT procedure codes 92626 and 92627 were deleted from the list of codes for Speech/Language Treatment and added to the list of codes for Speech/Language Assessment and Audiology Assessment.
7/1/06	Section 8.2	CPT code 97020 was deleted from the list of covered codes for Physical Therapy Treatment.